MARVEL
COSMETIC SURGERY

Patient Information Form

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB & Age _____ Race: _____ Gender: _____

Social Security Number: _____ Email _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ _____ ☐ Patient Referral: _____

☐ _____ ☐ Friend: _____

☐ Google: _____ ☐ Dr. Referral: _____

☐ Other:: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other:

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Skin Background: (Circle yes or no)

Do you use sunscreen on a regular basis? Yes No

Have you had sun exposure (or tanning bed) in the past 2 weeks? Yes No

Have you used Accutane with-in the last year? Yes No

Do you have scarring concerns? Yes No

Laser Resurfacing: (Circle yes or no)

Have you had laser resurfacing? Yes No

Do you have sundamage / brown spots / pigmentation concerns? Yes No

Do you use topical ointments? Retin-A Glycolic Lactic Acid Hydroqinone Other:

Do you have wrinkle concerns? Yes No

Have you had Botox/Dysport, Filler, or Collagen injections in the past 6 months? Yes No

Vaginal Rejuvenation: (Circle yes or no)

Painful sex? Yes No

Vaginal dryness? Yes No

Mild stress incontinence? Yes No

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

_____

Section I: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

	Have you or do you still have:	No	Yes	Description
2.	Asthma	☐	☐	
3.	Emphysema	☐	☐	
4.	High Blood Pressure	☐	☐	
5.	Heart Trouble	☐	☐	
6.	Hepatitis or Liver Trouble	☐	☐	
7.	Kidney Trouble	☐	☐	
8.	Diabetes	☐	☐	
9.	Epilepsy or Seizures	☐	☐	
10.	Stroke	☐	☐	
11.	Problem Scarring	☐	☐	
12.	Have you been advised to or had psychiatric care?	☐	☐	
13.	Others Not Listed:			

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

	Have any blood relatives had any of the following?	No	Yes	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	

Section IV: Family History (Cont'd)

	Have any blood relatives had any of the following?	No	Yes	Description
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, **please list and give reaction:**

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				
☐ Clinical staff may receive text/pictures on their phone should an emergency arrise that needs to be addressed.				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, Joanna Burcham, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Consent to Photograph or Film

I,_____ give consent that can photograph or film me but only to the extent necessary and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of documenting my health status, diagnosis adn treatment while a patient; (b) conducting education adn training, quality assurance and performance improvement functions for and on behalf of Dr. Jeffrey Marvel and his professional staff, and (c) publishing the results of my treatment on Dr. Jeffrey Marvel's website which, in this particular case, required me to sign the HIPAA authorization form.

The purpose of this form is to obtain my prior written consent so that Dr. Jeffrey Marvel may photograph or film me for one or more of the following purposes listed below for which I do hereby consent.

(INITIAL ALL PURPOSES THAT APPLY OR WRITE NO):

_____ Use or disclosure of images for marketing or advertisting purposes and patient education

_____ Use or disclosure of images for medical specialty board in formulating its examination of applicant physicians

_____ Use or disclosure of image in a professional presentation or journal publication

_____ Use or disclosure of images on Social Media sites for marketing and advertising purposes (ex:Facebook, Instagram, Snap Chat, YouTube etc.)

Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty board examinations.

I also agree to sign the HIPAA authorization form which permits Marvel Cosmetic - Nashville to use or disclosure these images but only to the extent permitted by HIPAA and other applicable laws and regulations.

COMPUTER IMAGINGDISCLAIMER

Computer imaging may be used to better educate you about your upcoming surgery. Althought an approximation of intended results is to be displayed, I realize that there are differences in graphic artistic ability and sugical technique. I realize that computer imaging does not constitute and should not be costructed to be an exact representation of post-surgical results. I understand that it is impossible to guarantee intended results. I understand that the alteration of any images is purely for the purpose of education, illustration and discussion.

_____ _____

Patient (or Patient's Legal Representative) Signature Date

_____ _____

Witness Date